

Healthy Seniors - Overview

Key Points

- *Missouri ranks 13th in the nation in the percent of people 65 years of age and over.*
- *A large percentage of seniors have chronic disease.*
- *Nationally, one in four seniors report spending at least \$100 per month on prescription medications.*

- Chronic conditions such as arthritis, diabetes, and heart disease often lead to declines in overall functioning and a reduced ability to remain in the community.
- Every year, chronic diseases account for more than 70% of the one trillion dollars the United States spends on health care expenditures.

Why is the health of seniors a critical issue for Missouri?

- Missouri ranks 13th in the nation in the percent of people 65 years of age and over.
- By 2025, Missouri's senior population is projected to be 1,625,394 or about 20% of Missouri's total population.

Chronic Disease

- The risk of chronic disease increases with age, so growth in Missouri's senior population will ensure an increase in the prevalence of chronic diseases in the state.
- In 1999, Missouri spent \$3 billion on cardiovascular disease-related hospitalizations.
- In 2000, 15.6% of Missouri seniors age 65 and over reported a diagnosis of diabetes.
- While seniors and persons with disabilities comprised 21.5% of Medicaid enrollees in 2001, Missouri spent 69.6% of its Medicaid funding on these seniors and persons with disabilities.
- Tobacco use, lack of physical activity, unhealthy eating behaviors and obesity are major contributors to the number of Missourians with chronic conditions.

Why is the health of seniors important?

Chronic disease produces a heavy economic burden on older adults due to long-term illness, diminished quality of life, and increased health care costs. Although the onset and severity of chronic disease increases with age, such conditions are not the inevitable consequences of aging.

- Four of the six leading causes of death among seniors are chronic diseases such as heart disease, cancer, stroke and COPD.
- Approximately 80% of all seniors have at least one chronic condition and 50% have at least two.
- African-American seniors have a higher incidence of lung disease, heart disease, and diabetes and significantly higher mortality rates as a result of these conditions, yet only about 47% of African-American seniors received the flu vaccine in 1998 compared to 66% of white seniors. In 1998, only about half as many African-American seniors received pneumonia vaccine compared to white seniors.

Chronic disease increases the need for higher levels of services.

- Chronic disease and related activity limitations increase the need for inpatient and extended care.

Immunization

- In 2001, only 67.5% of individuals aged 65 and older were immunized against influenza and only 56% were vaccinated against pneumococcal disease.
- There is currently no systematic approach to adult immunizations.
- Pneumonia and influenza are among the top ten causes of death in Missouri annually (resulting in 1,594 deaths in 2001) and disproportionately affect seniors age 60 and over.
- Adults and seniors age 18-64 may not have health insurance or may have insurance that doesn't cover influenza and pneumococcal vaccines.

Home and Community Care

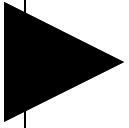
- In 2001, the average annual nursing home cost per resident was \$35,607. Keeping seniors in the community and out of nursing homes decreases

health care costs.

- The *Olmstead Decision* created the legal presumption that home and community care is preferable to institutional care.

Missouri SenioRx Program

- Estimates indicate that one-third of Medicare beneficiaries have no drug coverage at all. They must pay out of pocket for some or all of the cost of the prescription drugs they use. The total spending of seniors on prescription drugs increased 44 percent from 2000 to 2003.
- One in four seniors report spending at least \$100 per month on their prescription medications and 22% let prescriptions go unfilled and skip doses.
- During 2002, 18,800 seniors enrolled in Missouri's SenioRx program. For these seniors, this means a total of \$18 million dollars, directly attributable to their health, out of pocket savings to help them afford other necessities.

 SUCCESS INDICATORS	Healthy People 2010	2000 Baseline	2001 Actual	2002 Actual	2003 Target	2004 Target	2005 Target
Hospitalization rates (per 10,000 population) due to chronic diseases among Missouri senior adults:							
Diabetes with and without complications	25.7	42.0	48.2	Avail 7/04	36.1	34.8	33.1
Heart Disease (CVD)	657.7	1148.1	1208.8	Avail 7/04	984.4	942.2	895.1
Lung Disease (COPD)	68.5	114.0	129.4	Avail 7/04	97.8	93	88.4
Percentage of Missouri senior adults immunized:							
Influenza (persons 65 years of age)	90%	76.6%	67.5%	Avail 12/03	80.6%	81.9%	83.3%
Pneumococcal	90%	66.5%	56%	Avail 12/03	73.5%	75.9%	78.3%
Percent of unduplicated Missouri Care Options (MCO) screenings that result in authorization of state-funded home and community-based services	N/A	31%	60%	*	36%	39%	43%

*Data not available

Success Indicators:

- Rate of hospitalization due to the chronic diseases of heart disease, lung disease (COPD), and diabetes among Missouri senior adults
- Immunization rates among seniors for influenza

What are the trends?

In-Patient Hospitalization Rates (per 10,000) for Adults 65 years and older

Disease Specific	1996	1997	1998	1999	2000
Heart and circulation	1051.6	1071.7	1082.5	1101.6	1148.1
COPD and bronchitis-tasis	105.6	106.8	115.7	127.7	114.0
Diabetes without complications	0.7	0.8	1.0	1.2	1.1
Diabetes with complications	36.8	38.2	39.0	38.5	40.9

Source: Missouri Department of Health and Senior Services, Missouri Information for Community Assessment (MICA), 1996-2000

According to 2000 mortality indicators, Missourians are dying at higher rates from many chronic diseases, pneumonia and influenza, than the nation as a whole.

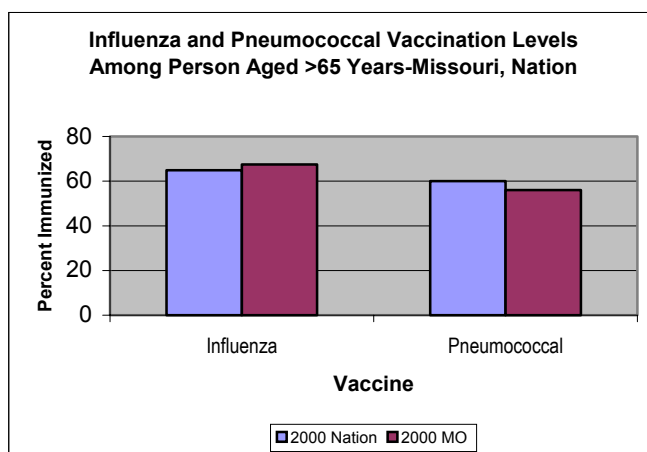
Missouri vs. United States Comparisons in Age-Adjusted Mortality Indicators 2000

	Missouri	U.S.	Difference
Cancer (all malignant neoplasms)	205.6	199.6	High
COPD	47.0	44.2	High
Diabetes	24.6	25.0	N/S
Heart Disease	288.3	257.6	High
Stroke	63.6	60.9	High
Lung Cancer*	63.6	56.1	High
Asthma	1.4	1.6	N/S
Pneumonia & Influenza	24.5	23.7	N/S

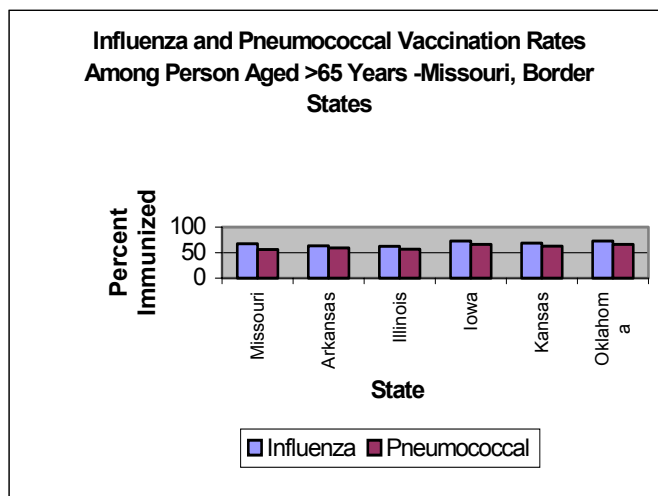
Source: Missouri Department of Health & Sr. Services, Bur. Of Health Data Analysis, and National Center for Health Statistics, *National Vital Statistics Reports Vol. 51, No. 9*

How does Missouri compare to others?

Although Missouri compares favorably with the 2000 national median for influenza and pneumonia diseases, it is still well below the Healthy People 2010 goal.



Source: CDC Risk Factor Survey, 2000 BRFSS



Source: CDC Risk Factor Survey, 2000 BRFSS

Rates are per 100,000 age-adjusted to U.S. 2000 standard population
 "N/S" indicates that the rates are not statistically significantly different at the .05 level.

* Includes trachea and bronchus.

Interventions that work:

Community Initiatives and Programs that Promote Physical Activity, Nutrition, and Immunization for Seniors

According to Assistant Secretary for Aging Josefina Carbonell, “No one is too old to enjoy the benefits of regular exercise. Healthy lifestyles, which include proper nutrition, are more influential than genetic factors in avoiding deterioration traditionally associated with aging.” The impact of *lack* of physical activity on medical costs is likely to grow as a result of the aging U.S. population, unless trends in physical activity change.

Evidence-based community preventive services that could be used to promote physical activity, nutrition, and immunization for seniors include:

Physical Activity —

- Clinicians are encouraged to work closely with patients to assess levels of physical activity and identify ways to overcome barriers to increasing those activity levels.
- Community-wide campaigns with messages regarding physical activity behavior for seniors promoted through television, radio, newspaper columns and inserts, and trailers in movie theaters.
- Individually-adapted health behavior change programs.
- Social support interventions in community settings that focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change. Strategies include creating new social networks

in a social setting, setting up a buddy system, contracting with another person to complete specified levels of physical activity, or establishing walking groups or other groups to provide friendship and support.

- Creation of, or enhanced access to, places for safe physical activity combined with informational outreach activities (e.g. building trails or facilities or reduce barriers to such places).

Nutrition —

- Programs such as Older Americans Act
- Nutrition Programs, 5 A Day for Better Health
- Farmers’ Market Nutrition Program.

Immunization —

- The Task Force on Community Preventive Service found that standing orders are effective in improving vaccine coverage among adults when used alone or as part of a multi-component intervention in a number of settings.
- Standing orders involve programs in which non-physician medical personnel prescribe or deliver vaccinations to clients without direct physician involvement at the time of the visit. These programs are carried out in clinics, hospitals, and nursing homes. Studies indicate that standing orders are particularly effective in improving the delivery of vaccines for influenza and pneumonia.

DHSS Strategy for Supporting the Intervention

1. Work with the providers of in-home services and the Area Agency on Aging to educate seniors on the importance of nutrition, physical activity, and immunization.

Success Indicator:

- Percent of unduplicated Missouri Care Options (MCO) screenings that result in authorization of state-funded home and community-based services

What are the trends?

From 1996 to 2001, the percentage of unduplicated MCO screenings resulting in home and community - based or residential care facility placement fluctuated.

Percentage of Unduplicated MCO Screenings Resulting in Home and Community-Based or Residential Care Facility Placement

	Screenings	*HCB	**RCF	Total	Percentage
2001	23,762	5,713	2,194	7,907	33.3%
2000	22,835	7,091	2,878	9,969	43.7%
1999	22,074	6,482	2,818	9,300	42.1%
1998	22,017	5,999	2,534	8,533	38.8%
1997	21,753	4,043	2,594	6,637	30.5%
1996	19,603	4,399	1,983	6,382	32.6%

Source: DHSS, Division of Senior Services, Research and Evaluation.

*Home and Community Based Services

**Residential Care Facility Placement

In 2001, the average annual nursing home cost per resident was \$35,607. In comparison, home and community-based services averaged \$4,177 annual cost per client. Residential care averaged \$4,672 annual cost per resident.

Keeping seniors in the community and out of nursing homes decreases health care costs.

How does Missouri compare to others?

There are no exact comparisons between Missouri and other states as other states don't have Missouri Care Options (MCO). However, other states' efforts to reduce nursing home admissions can be compared.

In 1995, Illinois mandated preadmission screening for all nursing home applicants regardless of income. Persons who didn't meet the state's standard of impairment could enter a nursing home using their own resources. Average Medicaid nursing home load dropped by more than 1,000 residents from 1996 to 1997.

In 1982, Oregon, through home and community services, made nursing home placement the placement of "last resort." From 1990 to 1996, Medicaid residents dropped by 900 despite the fact that the number of Oregonians aged 85 and over increased 40% during that time period.

In 1993, Maine:

- 1) Limited nursing home care to those with the most severe medical needs or disabilities;
- 2) Provided incentives to nursing homes to convert some beds to lower levels of care;
- 3) Increased appropriations for home care services;
- 4) Developed additional residential care options.

Result: The number of Medicaid residents dropped by almost 1,000 from 1995 to 1997.

Also, some states used Medicaid Home and Community Based Care Waiver programs to reduce nursing home placements by:

- 1) Expanding the range of services covered by the waiver to include home modification, emergency response systems and nutrition programs
- 2) Setting income eligibility standards for waiver services as high as 300% of the monthly SSI levels
- 3) Offering waiver and personal care services in residential care/assisted living facilities
- 4) Developing supportive housing care options.

Recent attention from the Missouri General Assembly resulted in appropriations to enhance the MCO function by creating a community counselor position to be placed in hospitals to assist in transitioning residents to the community from hospitals and nursing facilities.

Interventions that work:

Integrated Home and Community-Based Services

The U.S. Supreme Court's *Olmstead Decision* created the legal presumption that home and community care is preferable to institutional care. Consequently, Missouri is committed to increasing the number of seniors whose long-term care is provided in their homes and communities. The Missouri Care Options (MCO) program is a legislative initiative intended to ensure that adults who are facing decisions regarding long-term care are aware of information sufficient to exercise choice regarding the selection of their care.

MCO offers home and community long-term care services to adults 18 years and older who are Medicaid eligible, or potentially eligible, and in need of assistance. MCO also offers individuals who reside in long-term care facilities the option of home and community long-term care services if they qualify for care in a more independent setting.

In-home services include:

- Help with activities of daily living such as grooming, bathing, dressing, eating
- Help with complex physical needs
- A companion to relieve family caregivers, giving them time to run errands or attend to personal needs
- Help with housekeeping, laundry, etc.
- In-home nursing care
- Supervised adult day health care programs
- Nutritious meals delivered to the home through arrangements with the Area Agencies on Aging

DHSS Strategies for Supporting the Intervention

1. Discharge planning with hospitals to refer, inform and coordinate home and community services as options to nursing home care for seniors and their families.
2. Work with Division of Medical Services to expand the range of services covered by the waiver to include home modification, emergency response systems, transportation and nutrition programs.
3. Increase monitoring that focuses on quality of care versus paper compliance, implement outcome based contracts with more options for dealing with noncompliant providers, and require licensure for in-home service providers.